California Association of Health Plans Testimony for August 20, 2004

Hello, my name is Steve Tough and I am President/CEO of the California Association of Health Plans, and I appreciate having the opportunity to address the Commission today. Our association currently has 31 full-service health plan members operating in California, serving more than 22 million members across the state. Our members offer products ranging from commercial plans purchased by employers, labor unions, individuals and families, to state and federal programs including Healthy Families, Medicare, AIM and Medi-Cal.

We support the State of California's goals of improving the way it operates and provides services for the residents of California. Speaking specifically to suggested changes and improvements as recommended in the California Performance Review Report, I would like to make the following comments:

We support the State's efforts to expand its use of technology and automation to detect ineligible members, root out fraud and improve the auditing process to eliminate waste and unnecessary duplication. We were pleased that the CPR included a recommendation to streamline the audit functions at health plans, as considerable resources are being spent to respond to multiple audits by various government agencies and private accreditation organizations that are required or demanded by our purchasers. This improvement alone, will have tremendous value and permit the use of precious health care resources to be focused on targeted oversight, rather than processes and checklists.

We also believe that any change in the State's health care programs must be focused on expanding access to health care services for California's population. We are all well-aware of the high (and growing) numbers of uninsured across our State and we believe that creating greater access to health care and health coverage should be a primary motivating factor in any change.

With this in mind, we strongly support the State's recommendation to reinstate the $50 incentive fee for providing assistance in enrolling people into the State's Healthy Families program and implementing a similar fee for the combined application for Medi-Cal, CalWORKS and Food Stamps. A similar incentive fee was discontinued last year, and we have seen a decline in Healthy Families enrollment, which precludes the State from maximizing the federal funds available for this program. This program, promoted through grassroots, community-based organizations, can be an important step in increasing health access for children and the most vulnerable of our population.

We also support the concept of moving to a "One e App" for various programs that share the same eligibility requirements. By allowing enrollment into multiple programs with one application the State will save time and money and eliminate needless duplication in processing eligibility and enrollment.

We are concerned, however, with the implications and potential funding deficiencies that may occur with the elimination or blending of payments for the State's dual eligibles (the MediCare/Medi-Cal population), where members that are eligible for both federal

Medicare and State Medi-Cal. Often these dual eligibles have unique health care issues and needs that warrant a higher payment structure to ensure that they maintain access to the necessary health care services. This is a higher risk population and requires more health care services then the average population. Current payment rates for both Medi-Cal and Medicare are already low and payment reductions for a combined population could be problematic.

As for the recommendations affecting the Department of Managed Health Care, we understand the State's desire to streamline its organizational structure and reduce duplication. It is not yet clear as to whether the DMHC will be moved in whole under the DHHS Center for Quality Assurance or if the various functions of the DMHC will be spread out throughout various departments across the State structure. Functions, such as licensing, rule making, enforcement and complaint resolution, are integrated and co-dependent in many ways. We are concerned that the consolidation of functions for simplification could potentially lead to reduced efficiency due to "siloed" governmental oversight that is less responsive resulting in massive coordination across a large agency for even the most simple tasks.

We are also concerned with how regulatory oversight, product development and licensure will take place during the transition. Our member health plans are routinely creating new products or plans, or making changes to existing plan structures to meet the growing needs and demands of our consumers and the marketplace. We must ensure that the

licensing of these new products not be halted or delayed during the creation, development and implementation of the new oversight entity.

While the DMHC is still relatively young in age, it has made significant strides. All have worked together to develop processes that are currently working well. These processes include: licensing, creating regulations, product development, oversight, responding to member questions and grievances and enforcement to name a few. For the industry, the DMHC has provided for a single point of entry that has evolved to be both functional and accountable. We only ask that any changes contemplated ensure that the advances that have been made, and the processes which are working smoothly for consumers, not be lost in the transition or in the final structure.

Thank you.